

**BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

1. PLACE OF DEATH

County... Buchanan

Registration District No. 85

File No. 11

223

Township... St. Joseph

Primary Registration District No. 1001

Registered No. 62

City... St. Joseph

(No. St. Joseph Hospital)

St.

Ward

2. FULL NAME

(a) Residence. No. St. Ward. Savannah Mo.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U.S., if of foreign birth? 1 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Walter Deaton

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

June 16, 1885

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

46

7

1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

at Home 235

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Fallmore

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

Riley Bazill

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Fallmore

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Josephine Mann

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Fallmore

(STATE OR COUNTRY)

Mo.

14.

INFORMANT

W. R. Deaton

(Address)

Savannah Mo.

15.

FILED

1-17-32

John R. Bender

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

1-17 1932

17.

I HEREBY CERTIFY, That I attended deceased from 1-17, 1932, to 1-17, 1932 that I last saw her alive on 1-17, 1932, and that death occurred, on the date stated above, at 1.02 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Intestinal Obstruction
1278
1932 (duration) yrs. mos. 2 ds.

CONTRIBUTORY

(SECONDARY)

Jaundice (duration) yrs. mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

Home (Savannah)

DID AN OPERATION PRECEDE DEATH

yes DATE OF 1/17/32

WAS THERE AN AUTOPSY?

yes

WHAT TEST CONFIRMED DIAGNOSIS

Autopsy ①

(Signed)

M. H. Faltz

M. D.

, 19

(Address)

St. Joseph, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Savannah Mo.

1-19 1932

20. UNDERTAKER

ADDRESS

H. D. Sidenfaden

St. Joseph Mo.

N. 2.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....

Registration District No. 85

File No.

Township.....

Primary Registration District No. 1001

Registered No. 67

City St. Joseph (No.)

St.

Ward)

2. FULL NAME Fanny Deaton

(a) Residence, No. St. Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED M (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19..

19. UNDERTAKER (ADDRESS)

20. FILED 3-19-32 19..

John P. Bender
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jun 17 19 32

22. I HEREBY CERTIFY, That I attended deceased from

I last saw him alive on, 19..... Death is said

to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Infestional Obstruction
Caused by adhesive

Other contributory causes of importance:

Toxemia

Name of operation..... Date of

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed)....., M. D.

(Address).....

SUPPLEMENTARY

WRITE WITH UNFADING INK--THIS IS A PERMANENT RECORD

23. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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